Patient agreement to Chemotherapy
You have the right to change your mind at any time including after you have signed this form

Regime

<table>
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<tr>
<th>Special Requirements</th>
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Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)
I have explained the procedure to the patient/parent. In particular, I have explained:

The intended benefits:
- Improved survival
- Improved local control
- Symptom control

Serious or frequently occurring side effects:
- Risk of infection
- Mouth ulcers / sore mouth
- Diarrhoea
- Nausea/vomiting
- Menopause
- Tiredness / lethargy
- Poor appetite
- Altered taste
- Constipation

Risk of life threatening complications

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of those involved.

Breast feeding
- YES
- NO

Patient advised not to become pregnant during chemotherapy?
- YES
- NO
- N/A

Patient advised to use contraception / avoid partner

The following leaflet/tape has been provided

(Include version number)

Signed ________________________________ Date __________________

Name (PRINT) ________________________________ Job title __________________

Statement of interpreter (where appropriate)
- N/A

I have interpreted the information above to the patient/guardian to the best of my ability and in a way in which I believe s/he can understand.

Signed ________________________________ Date __________________

Name (PRINT) ________________________________
INTRA VENOUS / ORAL CHEMOTHERAPY SIDE EFFECT CHECKLIST

I confirm that I have had explained to me the following ticked side effects, that I may possibly experience, in relation to intravenous or oral chemotherapy treatment.

Side effects

- Hair loss
- Heart problems
- Kidney failure
- Fertility issues
- Steroid side effects
- Vein pain
- Nails / skin
- Red hands & feet syndrome
- Allergic reaction
- Other side effects
- Discoloured urine
- Tingling and numbness in fingers and toes
- Chest symptoms
- Rash
- Line related problems
- Risk of leaking at injection site
- Thrombosis
- Hearing loss

Statement of patient

I agree to the procedure described above.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

Signature ___________________________ Date __________________

Name (PRINT) ____________________________________________

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure, if the patient/guardian has signed the form in advance).

I have confirmed that the patient/guardian has no further questions and wishes the procedure to go ahead.

Signature ___________________________ Date __________________

Name (PRINT) ____________________________ Job title ____________________

White Copy - To be retained in patient’s notes
Blue Copy - GP
Yellow Copy - Given to patient